

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/18/2013	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052			
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00131013.</p> <p>Complaint IN00131013 substantiated. Federal/State deficiencies related to the allegations are cited at F362, F364, and F520.</p> <p>Survey Dates: July, 9, 10, 11, 12, 15, 16, 17, and 18, 2013</p> <p>Facility Number: 000468 Provider Number: 155378 AIM Number: 100290270</p> <p>Survey Team: Lora Brettnacher, RN-TC Jeanna King, RN Heather Lay, RN (July 9, 10, and 11, 2013)</p> <p>Census Bed Type: SNF/NF: 103 Total: 103</p> <p>Census Payor Type: Medicare: 11 Medicaid: 67 Other: 25 Total: 103</p>		F000000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 07/25/2013 by Brenda Nunan, RN.</p>						

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F000156 SS=E	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>						

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to provide liability notices to 1 of 3 residents reviewed for notification of Medicare non-coverage liability notices (Resident #44).</p> <p>Resident #44's record was reviewed on 7/11/2013 at 10:00 A.M. Resident #44 was admitted to the facility for rehabilitation services on 3/19/2013 and discharged to home on 3/28/2013. The record lacked documentation to indicated Resident #44 was provided a liability notice prior to discharge.</p> <p>During an interview on 7/11/13 at 10:15 A.M., the Administrator indicated the facility did not have documentation a "Notice of Medicare Non-Coverage" for Resident #44. During this interview the Administrator indicated Resident #44's Medicare benefits had not been exhausted and she should have been provided a liability notice prior to her discharge.</p> <p>3.1-4(a)</p>	F000156	<p>F156-Notice of Rights, Rules, Services, Charges: 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident discharged from the facility on 3/28/13 and cannot be specifically addressed. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Facility has audited all current residents to ensure all who should have received notification of Medicare non-coverage liability notices, did receive them. No other current residents have been effected by lack of Medicare non-coverage notification. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Social services, MDS department, and the Business office will be in-serviced on Medicare non coverage letter by the administrator on 8/6/13. The administrator or designee will monitor the completion of the Medicare non coverage letters daily (see Attachment A included with 2567 front page fax). 4.</p>		08/17/2013		

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			Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of the audits will be forwarded to the monthly Quality Assurance Meeting for further recommendation and review. The audits will continue daily for 30 days, weekly for 30 days and then monthly for 6 months to ensure continued compliance.		

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F000159 SS=D	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>						

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on observation and interview, the facility failed to ensure residents had access to personal funds managed by the facility on weekends. This deficient practice affected 2 of 8 residents interviewed regarding access to personal funds managed by the facility.</p> <p>Findings include:</p> <p>1. On 7/9/2013 at 10:30 A.M., an observation of a sign located on the receptionist desk indicated, resident funds were available from 8:30 A.M. to 3:30 P.M. - Monday through Friday.</p> <p>During an interview on 7/9/2013 at 1:31 P.M., Resident #62 indicated, no one was available to disperse money on the weekends.</p> <p>2. During an interview on 7/10/2013 at 10:48 A.M., Resident #25 indicated he could not get money out on the weekends. He further indicated he</p>			F000159	<p>F159-Facility Management of Personal Funds: 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Facility provided access to resident funds available Monday-Friday 8:30a-3:30p and Saturday and Sunday 10a-2p effective July 13, 2013. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Facility provided access to resident funds available Monday-Friday 8:30a-3:30p and Saturday and Sunday 10a-2p effective July 13, 2013. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Facility has provided notification via a letter to all residents and their responsible parties that resident funds are now available 7 days/week</p>		08/17/2013

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	<p>would have to remember to get money out before the weekend because he frequently ordered food from restaurants on the weekends.</p> <p>During an interview on 7/15/2013 at 2:19 P.M., the Administrator indicated, currently the facility did not have a system in place to ensure residents had access to their money managed by the facility during weekends.</p> <p>3.1-6(f)(1)</p>			<p>effective July 13, 2013. The facility management team was in-serviced on the new hours and new process by the Administrator on 7/12/13. Business Office Department or designee will complete an audit weekly to ensure that residents are able to obtain funds on the weekends (see Attachment B included with 2567 front page fax). 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of these audits will be forwarded to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue weekly for 30 days and then monthly for 6 months to ensure continued compliance.</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	F225-Investigate/Report			08/17/2013	

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	<p>review, prior to allowing an employee who had been accused of physically abusing a resident return to work, the facility failed to thoroughly investigate the abuse allegations for 1 of 3 allegations of abuse reviewed. This deficient practice had the potential to affect 1 of 1 resident who had contact with Staff #44 after she was allowed to return to work prior to a thorough investigation being completed.</p> <p>Findings include:</p> <p>During an interview on 7/10/2013 at 12:55 P.M., Resident #58 indicated she was talking to Staff #44 about financial issues when Staff #44 put her hands near her neck and shoulders and shook her. Resident #58 stated, "I don't know what got into her.... I was in her office and she shook me." Resident #58 demonstrated by taking both of her hands and placing them on her collar bone and stated, "She shook me. She didn't physically hurt me but she hurt my pride. I don't know what I did for her to do that to me. I have thought about reporting it to the lady who runs the place but they are friends. Besides if she was fired, I don't know what would happen to her two kids. I just want to let it go but if you have to tell you can use my</p>		<p>Allegations/Individuals: 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #58 is safe and free from any abuse or neglect. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Other residents that have contact with employee #44 have been interviewed and their safety ensured. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The Administrator and DON were in-serviced by the Regional Director of Operations on proper abuse and neglect investigation and reporting on 8/2/13. The Social Service Director was in-serviced by the Administrator on proper abuse and neglect investigation on 8/5/13. All staff will be in-serviced on 8/2, 8/5 and 8/6 by the SSD on abuse and neglect policy and procedure. The Administrator or designee will review each abuse/neglect concern for proper investigation using the investigation checklist as a guideline (see Attachment C included with 2567 front page</p>				

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	<p>name. I want it made perfectly clear, I don't want her anywhere near me or to speak to me ever again."</p> <p>During an interview on 7/10/2013 at 1:11 P.M., the Administrator and the Director of Nursing (DON) were informed of Resident #58's allegation of abuse. They both indicated an investigation would be started.</p> <p>On 7/15/2013 at 11:30 A.M., the Administrator provided the facility's completed investigation documentation for the allegation of abuse made by Resident #58. The Administrator was asked if she had provided the complete investigation. She indicated she had. The investigation indicated the facility had notified the Indiana State Department of Health (ISDH) of the allegations reported which included preventative measures that would be taken. This report indicated a preventative measure the facility would take included, "Resident interview will be started."</p> <p>The investigation indicated Resident #58 was interviewed by the DON. Resident #58 indicated to the DON, "...It was when I was upset about money. She grabbed me (pointed to shoulders) shook me. She didn't hurt</p>			<p>fax). 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The facility will include abuse and neglect investigations in our monthly quality assurance review for the next 6 months to ensure deficient practice does not recur.</p>			

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	<p>me. I thought I was going to have to move. Hands were around my neck pressing in hard. I was crying and upset. I don't want to get anyone in trouble. I think she should be talked to.... I was disappointed in her. I am still hurt. I was afraid. I was shocked at [Staff #44 named] violence.... It happened in the hallway by her office." The investigation indicated the abuse was unsubstantiated and the employee accused of the abuse was allowed to return to work. The complete investigation lacked documentation any residents other than the resident who made the allegation had been interviewed. The interviews that were conducted were from office staff. The investigation indicated Staff #44 indicated she talked to Resident #58 in her office. She never talked to her in the hallway. She indicated, "Never touched her shoulders, never squeezed her shoulders...." The investigation indicated Staff #44 was immediately suspended pending the investigation.</p> <p>During an interview on 7/16/2013 at 9:35 A.M., the Administrator stated, "We unsubstantiated it. She has a history of panic attacks and making false accusations. I have had to steady her myself. Through our</p>						

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	<p>investigation, this is what we think happened." When asked if residents were interviewed as was indicated on her report to the ISDH. She indicated, she did not do the investigation and referred me to the DON. The DON was asked if she interviewed any residents. She stated, " No, I did not." At this time, the Administrator and DON were informed their investigation was not thorough and they needed to interview residents. They indicated they would start immediately.</p> <p>On 7/17/2013 at 9:00 A.M., the Administrator provided interviews from residents who were recently admitted and would of had recent contact with Staff #44. One of those residents had contact with Staff #44 after she was allowed to come back to work prior to a thorough investigation was completed. A total of four resident interviews were completed. All denied concerns related to Staff #44.</p> <p>A current policy titled, "Abuse, Neglect and Misappropriation" and dated 4/2013, indicated, "...All allegations of abuse will be investigated and reported to the appropriate agencies. The Administrator/designee will make all</p>						

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	reasonable efforts to investigate and address alleged reports, concerns, and grievances...." 3.1-28(d)						

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to implement their abuse prevention policies for 1 of 3 allegations of abuse reviewed. This deficient practice had the potential to affect 1 of 1 resident who had contact with the accused staff after she was allowed to return to work and prior to the facility conducting a thorough investigation.</p> <p>Findings include:</p> <p>During an interview on 7/10/2013 at 12:55 P.M., Resident #58 indicated she was talking to Staff #44 about financial issues when Staff #44 put her hands near her neck and shoulders and shook her. Resident #58 stated, "I don't know what got into her.... I was in her office and she shook me." Resident #58 demonstrated by taking both of her hands and placing them on her collar bone and stated, "She shook me. She didn't physically hurt me but she hurt my pride. I don't know what I did for her to do that to me. I have</p>	F000226	<p>F226-Develop/Implement Abuse/Neglect, etc Policies: 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #58 is safe and free from any abuse or neglect. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Other residents that have contact with employee #44 have been interviewed and their safety ensured. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The Administrator and DON were in-serviced by the Regional Director of Operations on proper abuse and neglect investigation and reporting on 8/2/13. The Social Service Director was in-serviced by the Administrator on proper abuse and neglect investigation on 8/5/13. All staff will be</p>	08/17/2013			

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	<p>thought about reporting it to the lady who runs the place but they are friends. Besides if she was fired, I don't know what would happen to her two kids. I just want to let it go but if you have to tell you can use my name. I want it made perfectly clear, I don't want her anywhere near me or to speak to me ever again."</p> <p>During an interview on 7/10/2013 at 1:11 P.M., the Administrator and the Director of Nursing (DON) were informed of Resident #58's allegation of abuse. They both indicated an investigation would be started.</p> <p>On 7/15/2013 at 11:30 A.M., the Administrator provided the facility's completed investigation documentation for the allegation of abuse made by Resident #58. The Administrator was asked if she had provided the complete investigation. She indicated she had. The investigation indicated the facility had notified the Indiana State Department of Health (ISDH) of the allegations reported which included preventative measures that would be taken. This report indicated a preventative measure the facility would take included, "Resident interview will be started."</p>		<p>in-serviced on 8/2, 8/5 and 8/6 by the SSD on abuse and neglect policy and procedure. The Administrator or designee will review each abuse/neglect concern for proper investigation using the investigation checklist as a guideline (see Attachment C included with 2567 front page fax). 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The facility will include abuse and neglect investigations in our monthly quality assurance review for the next 6 months to ensure deficient practice does not recur.</p>				

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	<p>The investigation indicated Resident #58 was interviewed by the DON. Resident #58 indicated to the DON, "...It was when I was upset about money. She grabbed me (pointed to shoulders) shook me. She didn't hurt me. I thought I was going to have to move. Hands were around my neck pressing in hard. I was crying and upset. I don't want to get anyone in trouble. I think she should be talked to.... I was disappointed in her. I am still hurt. I was afraid. I was shocked at [Staff #44 named] violence.... It happened in the hallway by her office." The investigation indicated the abuse was unsubstantiated and the employee accused of the abuse was allowed to return to work. The complete investigation lacked documentation any residents other than the resident who made the allegation had been interviewed. The interviews that were conducted were from office staff. The investigation indicated Staff #44 indicated she talked to Resident #58 in her office. She never talked to her in the hallway. She indicated, "Never touched her shoulders, never squeezed her shoulders...." The investigation indicated Staff #44 was immediately suspended pending the investigation.</p>						

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	<p>During an interview on 7/16/2013 at 9:35 A.M., the Administrator stated, "We unsubstantiated it. She has a history of panic attacks and making false accusations. I have had to steady her myself. Through our investigation, this is what we think happened." When asked if residents were interviewed as was indicated on her report to the ISDH. She indicated, she did not do the investigation and referred me to the DON. The DON was asked if she interviewed any residents. She stated, " No, I did not." At this time, the Administrator and DON were informed their investigation was not thorough and they needed to interview residents. They indicated they would start immediately.</p> <p>On 7/17/2013 at 9:00 A.M., the Administrator provided interviews from residents who were recently admitted and would of had recent contact with Staff #44. One of those residents had contact with Staff #44 after she was allowed to come back to work prior to a thorough investigation was completed. A total of four resident interviews were completed. All denied concerns related to Staff #44.</p> <p>A current policy titled, "Abuse,</p>						

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	Neglect and Misappropriation" and dated 4/2013, indicated, "...All allegations of abuse will be investigated and reported to the appropriate agencies. The Administrator/designee will make all reasonable efforts to investigate and address alleged reports, concerns, and grievances...." 3.1-28(a)						

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F000247 SS=D	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on interview and record review, the facility failed to ensure residents were given notice prior to receiving a new roommate. This deficient practice affected 2 of 3 residents reviewed for advance notices being given prior to room changes and/or room mate changes (Resident #27 and Resident #143).</p> <p>Findings include:</p> <p>1. Resident #27's record was reviewed on 7/15/2013 at 12:54 P.M. A quarterly Minimum Data Assessment Tool (MDS) dated 5/7/13, indicated Resident #27 was alert and oriented without memory problems.</p> <p>During an interview on 7/10/2013 at 10:31 A.M., Resident #27 indicated she had recently received a new room mate and was not given notice. She stated, "They just brought her in as far as I can remember. No notice."</p> <p>2. Resident 143's record was reviewed on 7/15/2013 at 1:00 P.M. A quarterly Minimum Data</p>		F000247	<p>F247-Right to Notice before Room/Roommate Change: 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Roommate placement without notification occurred on 4/19/13 and 6/18/13 and cannot be specifically corrected. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Facility audited all room changes from 7/18/13 forward to ensure all roommates were notified of new roommate placement. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The Social Service Department and the Admissions Department were in-serviced on the new room change notification policy and procedure to include notification to the receiving resident by the Administrator on 7/19/13. The management team was also in-serviced on the new</p>		08/17/2013	

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	<p>Assessment Tool (MDS) dated 6/13/2013, indicated Resident #143 was alert and oriented without memory problems.</p> <p>During an interview on 7/9/2013 at 12:07 P.M., Resident #143 indicated, she had a room mate change and had not been given notice.</p> <p>During an interview on 7/16/2013 at 2:00 P.M., the Administrator indicated Resident #27 had a room mate change on 4/19/2013 and was unable to provide documentation of a notice being given to her prior to the change. She further indicated Resident #143 received a new room mate on 6/18/2013, and was unable to provide documentation she was given notice prior to the change.</p> <p>3.1-3(v)(2)</p>			<p>form by the Administrator for back up coverage on 7/19/13. The Administrator or designee will monitor the room change notifications weekly (see Attachment D included with 2567 front page fax). Facility implemented new room change notification forms that include notification to receiving roommate (see Attachment E-1 & E-2 included with 2567 front page fax). 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of these audits will be forwarded to the Monthly Quality Assurance Meeting for further review and recommendation. The audit will continue weekly for 30 days and then monthly for 6 months to ensure continued compliance.</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a coordinated comprehensive care plan for 1 of 1 residents reviewed for hospice care plans (Resident #95).</p> <p>Findings include:</p> <p>Resident #95's chart was reviewed on 7/15/2013 at 8:29 AM. Resident #95 had diagnoses which included, but were not limited to, mental retardation, hypothyroidism, recurrent urinary track infections, history of a bowel obstruction, and epilepsy.</p>	F000279	F279-Develop Comprehensive Care Plans: 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Facility scheduled a comprehensive care meeting with the hospice company on 8/2/13 to write a coordinated hospice care plan with measurable goals, specific interventions to meet goals, and which discipline would be providing the interventions to meet the goals. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility	08/17/2013			

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	<p>Resident #95's current care plan dated 7/11/13, indicated, he was admitted to Hospice care in April 2013 due to a failure to thrive. A goal listed indicated, "Resident will receive Hospice care tp [sic] resident's comfort level x 90 days." Approaches listed indicated, " (1) 4/17/2013 (75) Interdisciplinary team of LTC [Long Term Care] staff and Hospice staff to meet/adjust or modify POC [Plan of Care] to meet changing needs of the resident for physical, mental and spiritual needs. (2) 4/17/2013 (76) Honor resident's code status. (3) 4/17/2013 (77) Care plan meeting updates with resident/family members, hospice staff and LTC staff every 90 days and as needed." Disciplines listed to meet these goals indicated, "hos/IDT [hospice/Interdisciplinary team] and hos/MD/NSG [hospice/medical doctor/nursing]."</p> <p>Resident #95's record lacked documentation of a coordinated hospice care plan which indicated measurable goals, specific interventions to meet goals, and/or which discipline would be providing the interventions to meet the goals set for Resident #95.</p>		<p>took to correct the deficient practice for any client the facility identified as being affected. Facility scheduled meetings with all hospice companies currently providing care to our residents to write a coordinated hospice care plan with measurable goals, specific interventions to meet goals, and which discipline would be providing the interventions to meet the goals. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. All staff has been in-serviced on hospice care to include when they will be at facility, what services they will provide at the facility, and how to identify that a resident is Hospice while in the facility by the SDC on 8/2, 8/5 and 8/6. The MDS Coordinators have been in-serviced by the DON on developing care plans related to coordination of Hospice care. The DON or designee will monitor the care plan completion and coordination on a monthly basis for existing residents and with any new hospice admission (see Attachment F included with 2567 front page fax). 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of the</p>				

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	<p>During an interview on 7/15/2013 at 8:40 A.M., Licensed Practical Nurse (LPN) #7 stated, "He is not on Hospice. Last I heard he was going to quit." At this time she looked in Resident #95's chart and stated, "I thought he was off of it." LPN #7 indicated, hospice staff usually came on set days. If they couldn't make it, they would call and the facility staff would intervene and pick up the care. LPN #7 further indicated, the facility care plans and the hospice care plans were kept separate.</p> <p>3.1-35(a)</p>			<p>audits will be forwarded to the monthly Quality Assurance Meeting for further review and recommendations. The audits will continue monthly for 6 months and with all new admissions to ensure continued compliance.</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were provided care based on their written plan of care. This deficient practice affected 2 of 42 residents reviewed for services being provided based on their care plans (Resident #95 and Resident #18).</p> <p>Findings include:</p> <p>1. Resident #95's chart was reviewed on 7/15/2013 at 8:29 AM. Resident #95 had diagnoses which included, but were not limited to, mental retardation, hypothyroidism, recurrent urinary track infections, history of a bowel obstruction, and epilepsy.</p> <p>Resident #95 was observed sitting in a chair in a common area located by the nurse's station without his helmet on his head on 7/11/2013 at 1:00 P.M. and 1:59 P.M. (staff transferring him from his wheel chair to the recliner at this time, 7/15/2013 at 8:10 A.M., 8:15 A.M., and 8:19 A.M., and during constant observation from 8:30</p>	F000282	<p>F282-Services By Qualified Persons/Per Care Plan: 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #95's helmet was discontinued as a safety device by the physician due to resident's refusal to wear his helmet as part of his plan of care. Resident #18 is now being appropriately transferred with proper assistance. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Facility audited all current residents' safety devices to ensure accuracy and appropriateness. All aide assignment sheets were revised with updated safety device information. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. All nursing staff will be in-serviced on the necessity of</p>	08/17/2013			

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	<p>A.M. through 8:45 A.M. During this time, Resident #95 had his helmet in his hand. Staff were busy working around the area where Resident #95 was sitting. Staff were not observed to attempt to put Resident #95's helmet on.</p> <p>An un-timed physician's order dated 3/3//13, indicated Resident #95 must have his helmet on when he was up.</p> <p>A nurse's note dated 4/15/2013-1:130 P.M., indicated, Resident #95 was to have his helmet on when he was out of bed.</p> <p>A nurse's note dated 5/16/2013-9:30 A.M., indicated, a Certified Nursing Assistant (CNA) reported she thought Resident #95 had a seizure.</p> <p>A progress dated 6/21/2013-6:00 A.M., indicated, Resident #95 had seizure activity three times during the night.</p> <p>A physician's note dated 6/30/2013, indicated Resident #95 ambulated but had seizures and falls.</p> <p>A current 6/24/13, care plan indicated, Resident #95 was at risk for falls with injury related to an unsteady gait, impulsiveness related</p>		<p>following all safety devices and care plan information provided on the aide assignment sheets and nurses to be educated on the need to document any and all resident refusals related to safety devices or plans of care to determine whether they are effective interventions by the SDC on 8/2, 8/5 and 8/6. Unit managers will be educated on the need to keep all aide assignment sheets current and up to date to ensure resident safety by the DON on 8/6/13. The unit managers will complete an audit of all safety devices and care plan information daily to ensure in place and on the CNA assignment sheets (see Attachment G included with 2567 front page fax). 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of the audits will be forwarded to the Monthly Quality Assurance Meeting for further review and recommendation. The audit will continue daily for 30 days and then weekly for 30 days and then monthly for 6 months to ensure continued compliance.</p>				

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	<p>to mental retardation, and a diagnoses of epilepsy. A goal listed indicated, Resident #95 would have risk of injuries related to falls minimized by utilizing safety precaution measures. Approaches listed to meet this goal included ensure Resident #95 had his helmet on when he was up.</p> <p>During an interview on 7/11/2013 at 10:13 A.M., the Director of Nursing (DON) indicated, Resident #95 had a fall on 6/21/2013.</p> <p>During an interview on 7/15/2013 at 8:55 A.M., Licensed Practical Nurse #7 was asked how the CNAs new what special needs each resident required. She indicated they were given assignment sheets. At this time, she provided me with Resident #95's assignment sheet. The assignment sheet lacked documentation he needed to have a helmet on when he was out of bed. She further indicated, Resident #95 always had his helmet on. When informed he did not currently have it on and he had not had it on, she stated, "Well, he takes it off." Resident # 95's care plan lacked documentation of his refusal to wear his helmet.</p>						

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	<p>During an interview on 7/15/2013 at 9:01 A.M., CNA #8 (the CNA assigned to Resident #95) indicated she was informed when she was hired he was to have his helmet on when he was out of bed.</p> <p>2. Resident #18's chart was reviewed on 7/15/2013 at 9:06 A.M. She had diagnoses, which included but were not limited to, left below the knee amputee, diabetes, anxiety, cellulitis right lower leg, and depression. A quarterly Minimum Data Assessment Tool (MDS) dated 4/2013, indicated Resident #18 had a score of 11 out of 15 on the BIMS (Brief Interview Mental Screen). A score of 11 indicated she had moderately impaired cognition.</p> <p>A current care plan dated 5/16/2013, indicated Resident #18 was a fall risk with a history of falls, a recent left below the knee amputation, decreased mobility and pain. To increase safe transfers, staff were to transfer her with a mechanical lift at all times.</p> <p>During an interview on 7/10/2013 at 11:10 A.M., Resident #18 indicated, she was transferred by two staff members "last Monday". She stated, "...I have to slip my arm between their</p>						

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	<p>arms so they can pick me up and turn me around and sat me in the chair. They sat me on the edge of the chair and she let go of me and the other CNA had a hold of me and I started sliding out of the chair. I yelled out. I was sliding out of my chair...."</p> <p>During an interview on 7/16/2013 at 10:10 A.M., with the DON (Director of Nursing) and the Administrator present, the DON indicated Resident #18 was reliable 95% of the time.</p> <p>During an interview on 7/16/2013 at 11:50 A.M., NA #8 indicated, she was called in on her day off. She wasn't familiar with the residents on that hall, and her and another CNA put their arms under her arms and transferred Resident #18 from the bed to her wheel chair without a lift.</p> <p>3.1-35(g)(2)</p>						

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on record review and interview, the facility failed to ensure residents who required assistance with bathing were provided a minimum of 2 showers a week. This deficient practice affected 1 of 9 residents interviewed regarding bathing (Resident #27).</p> <p>Findings include:</p> <p>Resident #27's record was reviewed on 7/15/2013 at 12:54 P.M. Resident #27 had diagnoses which included a history of a stroke with right sided weakness and congestive heart failure. A quarterly Minimum Data Assessment Tool (MDS) dated 5/7/13, indicated Resident #27 was alert and oriented and required the physical assistance of one person for showers.</p> <p>During an interview on 7/10/2013 at 10:25 A.M., Resident #27 indicated she thought she only received one shower a week and she could use two because she gets "sweaty".</p>	F000312	<p>F312-ADL Care Provided for Dependent Residents: 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #27 is now receiving showers as requested. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Facility interviewed all residents or their responsible parties to ensure all residents shower needs were being met. Facility will revise aide assignment sheets to include additional shower requests. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The nursing staff will be in-serviced on the policy and procedure for completing showers to include what to do when a resident refuses and following the CNA assignment sheets for special</p>	08/17/2013			

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	<p>During an interview on 7/15/2013 at 1:16 P.M., Registered Nurse #1 indicated showers were documented in the hard chart on shower sheets and some were being documented in the kiosk. He further indicated, two showers a week was the minimum standard and if a resident refused it would be noted on the documentation and the care plan.</p> <p>On 7/16/2013 at 9:26 A.M., the Administrator provided documentation of Resident #27's showers for the months of March, May, June, and July of 2013. This documentation included shower records recorded on the shower sheets both from the hard record and the kiosk record. The documentation indicated, Resident #27 received no showers during the first week of March (3/1-3/7). She received one shower on 3/8, during the second week of March (3/8 - 3/14). She received one shower on 3/15/2013 during the the third week of March (3/15-3/21). Documentation of showers given in April was not available. She received no showers the first week of May (5/1-5/7), one shower on May 12, 2013, during the second week of May (May 8-May 14). She received no showers for the first week of June (6/1-6/7), one shower</p>				<p>requests by the SDC on 8/2, 8/5, and 8/6/2013. The unit managers will monitor the ADL books and interview 2 residents daily to ensure showers are completed as requested and at a minimum of two times a week (see Attachment H included with 2567 front page fax). 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of the audits will be forwarded to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue daily for 30days and then weekly for 30 days and then monthly for 6 months to ensure continued compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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	<p>on June 14, during the second week of June (6/8-6/14). She received one shower on June 28, during the 4th week of June (6/22- 6/30). She received one shower on July 12, 2013 for the second week of July (7/8-7/14). Documentation was lacking which indicated Resident #27 refused showers.</p> <p>Review of a current policy titled, "Showers" and dated 12/10, provided by the administrator on 7/17/2013 at 2:00 P.M., indicated, "The residents will be provided a shower, as appropriate, at least two (2) times per week according to established shower schedule...."</p> <p>3.1-38(3)(b)(2)</p>						

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview, and record review, the facility failed to utilize a recommended mechanical lift to transfer a resident resulting in pain caused by bumping the resident's leg during the transfer. This deficient practice affected 1 of 4 residents reviewed for accidents (Resident #18).</p> <p>Findings include:</p> <p>During an interview on 7/10/2013 at 11:17 A.M., Resident #18 stated, "...I am in enough pain.... Last Monday they were taking me off the bed to put me in the wheel chair. I have to slip my arm between their arms so they can pick me up and turn me around and sat me in the chair. They sat me on the edge of the chair and she let go of me and the other CNA [Certified Nursing Assistant] had a hold of me. I started sliding out of the chair. I yelled out. I was sliding out of my chair and she just stood there. [CNA #9 named] was trying to pull me up in the chair and I told her, 'Young lady</p>	F000323	<p>F323-Free of Accident Hazards/Supervision/Devices: 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #18 is now being appropriately transferred with proper assistance. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Facility audited all current residents' safety devices to ensure accuracy and appropriateness. All aide assignment sheets were revised with updated safety device information including the appropriate and safe way to transfer each resident. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The nursing staff will be in-serviced on following the transfer techniques appropriately and safely and</p>	08/17/2013			

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	<p>get over here and help [CNA #9 named] pull me up. She can't do it herself.' and she just stood there. I started crying because I fell and she could have prevented it.... I hurt my leg.... The next day it started hurting real, real bad. They gave me pain pills and it helped." Resident #18 pointed to her left stump.</p> <p>During an interview on 7/16/2013 at 10:10 A.M., the DON indicated Resident #18 reported concerns regarding the transfer assisted by NA (Nurses Aide) #8 the day after it happened. As a result NA #8 was terminated. She clarified the incident occurred on July 6, 2013, not on Monday (July 8, 2013) as the resident indicated. She further indicated Resident #18 was "95% reliable".</p> <p>During a phone interview on 7/16/2013 at 11:50 A.M., terminated NA #8 stated, "This was my first job as an aide. I haven't even taken my test yet. It was my day off and they called me in a hour and a half before the shift because they were short. I didn't know those residents. Yes, I had an assignment sheet but [Resident #18 named] was not my patient so I didn't take the time to look at her stuff. I answered the call light and told her I could not get her up on</p>		<p>using appropriate safety devices for each resident by the SDC on 8/2, 8/5, and 8/6/2013. This will include where to find the appropriate information. The unit managers will complete an audit daily of all safety devices and ensure that CNA assignment sheets are up to date with correct transfer and safety device information (see Attachment G included with 2567 front page fax). 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of the audits will be forwarded to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue daily for 30 days, weekly for 30 days and then monthly for 6 months in order to ensure continued compliance.</p>				

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	<p>my own. She was upset. I told the nurse. She said she was passing meds [medications] and she would have to wait. The other Aide was off the floor.... Most of those people take two staff to get up. I couldn't do it all by myself. If she would have fell and hurt herself then I really would have been in trouble. No we did not use the lift. We sat her up on the side of the bed, put our arms under her arms, and transferred...."</p> <p>During an interview on 7/17/2013 at 1:59 P.M., with the DON, Administrator, and a corporate staff present, LPNf #10 indicated, if "as needed" pain medication was administered, documentation would be noted on the MAR of the time you gave it, the intensity, and follow-up to see if it was effective using the 1-10 number scale.</p> <p>Resident #18's chart was reviewed on 7/15/2013 at 9:06 A.M. She had diagnoses, which included but were not limited to, left below the knee amputee, diabetes, anxiety, cellulitis to her right lower leg, and depression.</p> <p>A current care plan dated 5/16/2013, indicated Resident #18 was a fall risk with a history of falls, a left below the knee amputation, decreased mobility,</p>						

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	<p>and pain. To increase safe transfers, staff were to transfer her with a mechanical lift at all times.</p> <p>Physician's orders dated 2/15/12, indicated Resident #18 had an order for Tramadol HCL 50 Milligrams four times daily for pain.</p> <p>Physician's orders, dated 6/28/12, indicated Resident #18 had Tylenol 650 Milligrams three times daily for pain.</p> <p>Physician's orders, dated 3/6/12, indicated Resident #18 had routine orders for Hydrocodone-APAP (narcotic pain reliever) 5/500 Milligrams every evening for pain and Vicodin (Hydrocodone-APAP) 5/500 Milligrams every 4 hours as needed for pain.</p> <p>Nurse's notes were reviewed from June 1, 2013 through July 6, 2013. Documentation indicated, throughout these notes, Resident #18 denied pain or discomfort.</p> <p>A nurse's note dated 7/6/2013-6:00 A.M., indicated, Resident #18 reported her current scheduled pain medications were effective in controlling her chronic pain issues.</p>						

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	<p>May 2013 and June 2013, Medication Administration Records [MAR] indicated, Resident #18 took the "as needed" Vicodin once during these two months.</p> <p>A nurse's note dated 7/7/13-7:00 P.M., indicated, "Reports pain in L [left] stump this evening. Reports it has ached all day...."</p> <p>The MAR for July 2013, indicated Resident #18 received an "as needed" Vicodin on July 7th at 11:00 A.M.</p> <p>During an interview on 7/18/2013 at 6:47 A.M., the DON indicated, the nurse who gave Resident #18 the "as needed" pain medication on July 7, 2013 contacted her and informed her she gave the additional pain medicine for "back and leg pain."</p> <p>3.1-45(a)(2)</p>						

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F000362 SS=E	<p>483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. Based on observation, interview, and record review, the facility failed to ensure there were sufficient dietary support staff to ensure meals were served timely for 1 of 2 dining observations and for 16 of 23 residents reviewed regarding food quality and service.</p> <p>Findings include:</p> <p>On 7/9/2013 at 11:30 A.M., an observation of a sign posted by the Rosewood Cafe dining area was made. The sign indicated, breakfast was served at 8:15 A.M., lunch was served at 12:15 P.M., and dinner was served at 6:15 P.M.</p> <p>Constant observations were made of the Rosewood Cafe dining room on 7/9/2013, beginning at 12:24 P.M. and ending at 1:25 P.M. The following observations were made:</p> <p>12:24 P.M.- 16 residents seated in the dining room waiting to be served. No food being served.</p> <p>12:31 P.M.- one staff offering only cold drinks at this time. She indicated</p>	F000362	<p>F362-Sufficient Dietary Support Personnel: 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Effective 7/15/13, facility revised serving times and staff allocation to ensure 2 staff members are available in the main dining room 15 minutes prior to serving time to pass all drinks and serve trays timely. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Effective 7/15/13, facility revised serving times for all dining areas and staff allocation to ensure enough staff in each serving area to provide food timely. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Facility in-serviced nursing and dietary staff on 7/12/13, to educate staff on new dining plan. Serving times were revised for accuracy and staff was re-assigned to</p>	08/17/2013			

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	<p>she would come back and provide the hot drinks when she was done. Carts being filled with trays of food to be taken to other areas in the facility.</p> <p>12:35 P.M.- last person in the room was offered a cold drink.</p> <p>12:39 P.M.- residents who wanted hot drinks were served hot drinks.</p> <p>12:50 P.M.- last resident who wanted a hot drink was served his drink.</p> <p>12:52 P.M.-first tray delivered to a resident. At this time, two staff observed serving trays.</p> <p>1254 P.M.- second tray served to a resident</p> <p>12:56 P.M.- Resident yelled out, "Where is the food." Staff responded, "Its coming, we are running behind."</p> <p>1:05 P.M.-12 of [now] 20 residents sitting in the dining room had not been served lunch.</p> <p>1:10 P.M.- 10 residents not served lunch</p> <p>1:16 P.M.- 5 residents still not served lunch.</p> <p>1:17 P.M.- Resident A was served ice cream. Staff removed the lid when they brought. The ice cream was melted almost to liquid.</p> <p>1:18 P.M.- Resident A was asked if he liked his ice cream melted. He replied,"No, but it's that way by the time it gets here."</p> <p>1:20 P.M.- the last resident in the room was served lunch</p>		<p>different areas to ensure enough staff in each location to provide residents timely meal service. The Dietician or designee will complete an audit of the meal service 3x daily for first 2 weeks, 1x daily for next 2 weeks, then 3x weekly for 30 days, then 1x weekly for 30 days. This will include timeliness of meals being served, food temps and interview of 3 residents each day alternating the resident who eat in the dining room and the resident who eat in their room (see Attachment I included with 2567 front page fax). The resident council minutes will be reviewed by the Administrator and Dietician following the meeting to ensure timely follow up of dietary concerns. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of the audits will be forwarded to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue three times weekly for 30 days then weekly for 30days and then monthly for 6 months to ensure continued compliance.</p>				

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	<p>During observations on 7/10/2013 at 12:42 P.M., staff served Resident A ice cream that was near liquid consistency. Resident A stated, "Yes, it is liquid again today."</p> <p>Interviews with residents and family:</p> <p>7/9/2013 at 11:50 A.M., Resident P indicated, at times her food is cold. Her toast was usually burned and she ate a lot of peanut butter and jelly sandwiches because the food was not so good.</p> <p>7/9/2013 at 12:05 P.M., Resident N indicated, her food was cold more than it was not.</p> <p>7/9/2013 at 12:15 P.M., Resident L stated, "cold is warm and hot is warm by the time they get it too you.... You drink the ice cream. It was that way today. Pretend it is a shake and go on if you like warm ice cream.... Yes, I have not eaten because it was too cold or too hot when it should have been cold."</p> <p>7/9/2013-12:30 P.M.-Resident C stated, "There is usually only one or two staff in here serving, cutting, and setting up trays. They need something. I swear.... We are</p>						

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	<p>supposed to be served at 12:15. I come down here at 12:00 ."</p> <p>7/9/2013-1:22 P.M.- Resident B's family member stated, "He has been here since 11:30 A.M.,.... He didn't get his food until after 1:00 today. That is too long... Sometimes he gets so disgusted he will wheel himself back to his room without eating. He has done that several times...."</p> <p>7/9/2013 at 1:28 P.M., Resident E indicated, meals were served late and ninety percent of the time she didn't get what she ordered.</p> <p>7/10/2013-9:55 A.M., Resident F indicated, most of the time the food was not appetizing. It was continually cold and usually late because there was not enough staff.</p> <p>7/10/2013 -10:28 A.M.- Resident D stated, "I eat in my room. Sometimes it is cold. No certain meal. It depends on how long it takes to get here and how warm it is when it leaves the kitchen.... The ice cream is usually pretty soft when I get it...."</p> <p>7/10/13 at 10:44 A.M., When asked if the food taste good and looked appetizing Resident G replied, "It sucks. The ice cream is like a</p>						

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	<p>milkshake. It is drinkable.... I am so displeased with the food, I don't eat it...I have told every body." He further indicated the food was not served at proper temperatures and his family had to bring him food from the outside.</p> <p>7/10/2013 at 11:21 A.M., Resident I indicated once and a while there was not enough staff to serve trays and it happened again last night.</p> <p>7/11/2013 at 9:49 A.M., When asked if the food was served at the proper temperature, Resident H responded, "some of it is cold...everyday its cold."</p> <p>7/10/2013 at 10:05 A.M., Resident K indicated she ate in the dining room. Her eggs were sometimes cold. She had to wait a long time to be served at all meals. She further indicated she felt it was sometimes due to staff "not taking their job seriously" and "sometimes their was just not enough staff down there."</p> <p>7/10/2013 at 11:38 A.M., Resident O indicated she had to wait up to an hour to be served at times in the dining room.</p> <p>7/10/2013 at 1:57 P.M., Resident M indicated, he ate in his room and sometimes his food was cold.</p>						

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	<p>7/11/2013 at 1:14 PM, Resident F stated, "The food is awful. I spoke to the chef. It is cold...and no variety."</p> <p>7/15/2013 at 8:41 A.M., Resident F was observed eating breakfast. At this time she indicated, her food wasn't any better today because her eggs were cold again.</p> <p>Interview with facility staff:</p> <p>7/9/2013 at 1:32 P.M., Licensed staff #14 stated, "It happens frequently. The start times are late. There isn't enough help in here to serve. The office is supposed to help but they don't.... Staff will come to the window to pick up there own lunch while residents are sitting and waiting to eat.... Something needs to be done."</p> <p>7/15/2013 at 9:53 A.M., Dietary Staff #13 indicated, she felt the problem with the food being cold and long wait times had to do with not enough servers and getting late starts in the kitchen.</p> <p>7/15/2013 at 9:56 A.M., the Dietary Manager stated, "We are constantly having to page to get people down here to help pass trays. We are short staffed in the kitchen Four people</p>						

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	<p>now. Two quit last week. We were already short so we run behind a little but we usually catch up and then we have to wait and wait for staff to pass trays. The food is hot when it goes out because we take temps [temperatures] but by the time it goes to the floor, it probably is cold, and that's the reason residents are complaining."</p> <p>Resident Council Minutes were reviewed for the months of January 2013 through June 2013. The minutes for February 2013, indicated, Resident felt there "was not enough staff at times." The minutes for March 2013 indicated, Residents felt there needed to be more staff. The minutes for April 2013, indicated, Residents had complaints of "food not being warm enough" and "wait times for meals." The minutes for May 2013, indicated, Residents had complaints of the "food not always being hot enough", the "ice cream is melted at times", and "meals are late at times."</p> <p>During an interview on 7/16/2013 at 9:24 A.M., the Administrator indicated the facilities Quality Assessment Committee had identified concerns with cold food and residents having to wait long periods of time to be served</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013
FORM APPROVED
OMB NO. 0938-0391

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	<p>meals through observations and the Resident Council Minutes. She indicated the Resident Council Minutes in March alluded to problems with cold food and wait times, however, audits had not been started until July 1, 2013, to address the concerns.</p> <p>This Federal tag relates to Complaint IN00131013.</p> <p>3.1-20(h)</p>						

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F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview, and record review, the facility failed to provide residents food that was palatable and served at appropriate temperatures for 16 of 23 residents reviewed for food quality.</p> <p>Findings include:</p> <p>On 7/9/2013 at 11:30 A.M., an observation of a sign posted by the Rosewood Cafe dining area was made. The sign indicated, breakfast was served at 8:15 A.M., lunch was served at 12:15 P.M., and dinner was served at 6:15 P.M.</p> <p>Constant observations were made of the Rosewood Cafe dining room on 7/9/2013, beginning at 12:24 P.M. and ending at 1:25 P.M. The following observations were made:</p> <p>12:24 P.M.- 16 residents seated in the dining room waiting to be served. No food being served.</p> <p>12:31 P.M.- one staff offering only cold drinks at this time. She indicated</p>	F000364	<p>F364-Nutritive Value/Appear, Palatable/Prefer Temp: 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Effective 7/15/13, facility revised serving times and staff allocation to ensure 2 staff members are available in the main dining room 15 minutes prior to serving time to pass all drinks and serve trays timely to ensure appropriate food temperatures. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Effective 7/15/13, facility revised serving times for all dining areas and staff allocation to ensure enough staff in each serving area to provide food timely and to ensure appropriate food temperatures. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Dietary staff to be</p>	08/17/2013			

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	<p>she would come back and provide the hot drinks when she was done. Carts being filled with trays of food to be taken to other areas in the facility.</p> <p>12:35 P.M.- last person in the room was offered a cold drink.</p> <p>12:39 P.M.- residents who wanted hot drinks were served hot drinks.</p> <p>12:50 P.M.- last resident who wanted a hot drink was served his drink.</p> <p>12:52 P.M.-first tray delivered to a resident. At this time, two staff observed serving trays.</p> <p>1254 P.M.- second tray served to a resident</p> <p>12:56 P.M.- Resident yelled out, "Where is the food." Staff responded, "Its coming, we are running behind."</p> <p>1:05 P.M.-12 of [now] 20 residents sitting in the dining room had not been served lunch.</p> <p>1:10 P.M.- 10 residents not served lunch</p> <p>1:16 P.M.- 5 residents still not served lunch.</p> <p>1:17 P.M.- Resident A was served ice cream. Staff removed the lid when they brought. The ice cream was melted almost to liquid.</p> <p>1:18 P.M.- Resident A was asked if he liked his ice cream melted. He replied,"No, but it's that way by the time it gets here."</p> <p>1:20 P.M.- the last resident in the room was served lunch</p>		<p>educated, on 7/31/13, about the need for meal service to be timely to ensure food stays at proper temperature. Staff also educated about the need to ice down all cold foods, including ice cream, to ensure food stays at proper temperature. The Dietician or designee will complete an audit of the meal service 3x daily for first 2 weeks, 1x daily for next 2 weeks, then 3x weekly for 30 days, then 1x weekly for 30 days. This will include timeliness of meals being served, food temps and interview of 3 residents each day alternating the resident who eat in the dining room and the resident who eat in their room (see Attachment I included with 2567 front page fax). The resident council minutes will be reviewed by the Administrator and Dietician following the meeting to ensure timely follow up of dietary concerns. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of the audits will be forwarded to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue three times a weekly for 30 days then weekly for 30 days and then monthly for 6 months to ensure continued compliance.</p>				

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	<p>During observations on 7/10/2013 at 12:42 P.M., staff served Resident A ice cream that was near liquid consistency. Resident A stated, "Yes, it is liquid again today."</p> <p>Interviews with residents and family:</p> <p>7/9/2013 at 11:50 A.M., Resident P indicated, at times her food is cold. Her toast was usually burned and she ate a lot of peanut butter and jelly sandwiches because the food was not so good.</p> <p>7/9/2013 at 12:05 P.M., Resident N indicated, her food was cold more than it was not.</p> <p>7/9/2013 at 12:15 P.M., Resident L stated, "cold is warm and hot is warm by the time they get it too you.... You drink the ice cream. It was that way today. Pretend it is a shake and go on if you like warm ice cream.... Yes, I have not eaten because it was too cold or too hot when it should have been cold."</p> <p>7/9/2013-12:30 P.M.-Resident C stated, "There is usually only one or two staff in here serving, cutting, and setting up trays. They need something. I swear.... We are</p>						

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	<p>supposed to be served at 12:15. I come down here at 12:00 ."</p> <p>7/9/2013-1:22 P.M.- Resident B's family member stated, "He has been here since 11:30 A.M.,.... He didn't get his food until after 1:00 today. That is too long... Sometimes he gets so disgusted he will wheel himself back to his room without eating. He has done that several times...."</p> <p>7/9/2013 at 1:28 P.M., Resident E indicated, meals were served late and ninety percent of the time she didn't get what she ordered.</p> <p>7/10/2013-9:55 A.M., Resident F indicated, most of the time the food was not appetizing. It was continually cold and usually late because there was not enough staff.</p> <p>7/10/2013 -10:28 A.M.- Resident D stated, "I eat in my room. Sometimes it is cold. No certain meal. It depends on how long it takes to get here and how warm it is when it leaves the kitchen.... The ice cream is usually pretty soft when I get it...."</p> <p>7/10/13 at 10:44 A.M., When asked if the food taste good and looked appetizing Resident G replied, "It sucks. The ice cream is like a</p>						

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	<p>now. Two quit last week. We were already short so we run behind a little but we usually catch up and then we have to wait and wait for staff to pass trays. The food is hot when it goes out because we take temps [temperatures] but by the time it goes to the floor, it probably is cold, and that's the reason residents are complaining."</p> <p>Resident Council Minutes were reviewed for the months of January 2013 through June 2013. The minutes for February 2013, indicated, Resident felt there "was not enough staff at times." The minutes for March 2013 indicated, Residents felt there needed to be more staff. The minutes for April 2013, indicated, Residents had complaints of "food not being warm enough" and "wait times for meals." The minutes for May 2013, indicated, Residents had complaints of the "food not always being hot enough", the "ice cream is melted at times", and "meals are late at times."</p> <p>During an interview on 7/16/2013 at 9:24 A.M., the Administrator indicated the facilities Quality Assessment Committee had identified concerns with cold food and residents having to wait long periods of time to be served</p>						

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	<p>meals through observations and the Resident Council Minutes. She indicated the Resident Council Minutes in March alluded to problems with cold food and wait times, however, audits had not been started until July 1, 2013, to address the concerns.</p> <p>This Federal tag relates to Complaint IN00131013.</p> <p>3.1-21(a)(2)</p>						

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F000406 SS=D	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on observation, record review, and interview, the facility failed to provide specialized rehabilitative services for 2 of 2 residents reviewed with diagnoses of mental retardation (Resident #95 and Resident #5).</p> <p>1. Resident #95's record was reviewed on 7/15/2013 at 8:29 A.M. Resident #95 was admitted to the facility on 3/3/13 and had a diagnoses which included mental retardation.</p> <p>During an interview on 7/15/2013 at 1:36 P.M., the Social Service Designee was asked to provide Resident #95's Level II Pre-Admission Screening and Annual Resident Review.</p> <p>During an interview on 7/16/2013 at 9:24 A.M., the Administrator indicated</p>	F000406	<p>F406-Provide/Obtain Specialized Rehab Services (Level II): 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #95's Level II Pre-Admission screening was initiated on 7/15/13 to correct deficient practice. Resident #5 was referred to PT, OT, ST for screening on 8/2/13. Resident #5 has been referred to all ancillary services (optometry, audiology, dental, and medical). Resident #5 is being re-assessed for one-on-one activities to meet his SRS needs. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Facility will audit all current residents to ensure that Level II Pre-Admission screenings are</p>	08/17/2013			

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	<p>Resident #95's Pre-Admission Screening and Annual Resident Review could not be located.</p> <p>During an interview on 7/18/2013 at 9:46 A.M., with Social Service (SS) Employee #2, SS Employee #3, and the SSD (Social Service Director) present, SS Employee #2 indicated, the required Level II screening was not completed for Resident #95 because when he was originally admitted he was supposed to only be short term. They had intended for him to return to the group home where he lived previously. She further indicated, the required Level II screening should have been initiated after his stay extended past 30 days.</p> <p>2. On 7/10/2013 at 1:36 P.M. and 7/11/2013 at 1:30 P.M., Resident #5 was observed sitting in a room across from the nursing station by himself. His eyes were open and he was chewing on his hands and making sounds. There was a television on in the room on a channel with soap operas.</p> <p>During an interview on 7/15/2013 at 1:36 P.M., the Social Service Designee was asked to provide Resident #5's Level II Pre-Admission Screening.</p>			<p>initiated for residents who meet criteria and will ensure that all SRS recommendations are being followed. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The Social Service Department, the Business Office, and the Admissions Department were in-serviced by the Administrator on Level II completion on 8/6/2013. The Social Service Department was in-serviced by the Administrator on following SRS recommendation for the MRDD resident in the facility on 8/5/2013. The Administrator or designee will monitor level II completion and SRS recommendation completion weekly (see Attachment J included with 2567 front page fax). 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of the audits will be forwarded to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue weekly for 30 days then monthly for 6 months to ensure continued compliance.</p>			

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	<p>On 7/16/2013 at 9:24 A.M., the Administrator provided Resident #5's Level II service plan. Resident #5's service plan indicated, Resident #5 received a Level II on 2/28/2013. He had a developmental disability and required a review in one year. He required Specialized Rehabilitation Services(SRS) for a developmental disability. He did meet the PASSAR Level II criteria for continued residence in a nursing facility for nursing services for medical needs. His SRS needs included habilitation training, occupational therapy, physical therapy, speech/language therapy, recreation/leisure activities, and additional evaluations or exams specified as routine optometry, audiology, dental and medical follow along.</p> <p>During an interview on 7/17/2017 at 2:27 P.M., Registered Nurse #5 was asked what the facility did for Resident #5. Registered Nurse #5 stated, "I don't think much. He sits in that chair and watches TV or he is in his bed. I don't think he comprehends anything."</p> <p>During an interview on 7/17/2013 at 3:10 P.M., the Director of Nursing (DON) was asked to provide</p>						

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	<p>documentation of the services being provided to Resident #5 according to his Level II Pre-Admission-Screening Plan.</p> <p>During an interview on 7/18/2013 at 9:46 A.M., with Social Service (SS) Employee #2, SS Employee #3, and the SSD present, the SSD indicated, he had observed that Resident #5 was only lounging in front of the TV. He indicated the facility had not provided Resident #5 with occupational or speech/language therapy services. The SSD further indicated the facility did not have an appropriate care plan in place which met the requirements of Resident #5's rehabilitation plan and programing needs.</p> <p>3.1-23(a)(1)</p>						

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure refrigerators which stored resident medication were monitored</p>	F000431	F431-Drug Records, Label/Store Drugs & Biologicals: 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Facility		08/17/2013		

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	<p>for accurate temperatures for 1 of 9 medication refrigerators utilized in the facility.</p> <p>Findings included:</p> <p>On 7/17/13 at 1:40 P.M., an observation of the medication refrigerator located on the Maplewood unit was observed to contain Lorazepam, TB serum, Biscodyl suppositories, Lantus insulin, Novalog insulin, and Vancomycin IV medication (intravenous). At this time the DON (Director of Nursing) was asked to provide documentation which indicated the refrigerator temperatures were being monitored.</p> <p>During an interview on 7/17/13 at 1:40 P.M., the DON (Director of Nursing) indicated, that all refrigerators which stored medications were required to have daily monitoring of temperatures. She further indicated she was unable to provide documentation which indicated the medication refrigerator had been monitored for accurate temperatures.</p> <p>A current policy titled, "Storage of Medications" and dated 10/31/09, provided by the Administrator on 7/18/13 at 8:00 A.M., indicated,</p>				<p>added missing temperature log to Maplewood refrigerator effective July 17, 2013. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All refrigerators which store resident medications will be audited and monitored to ensure temperature logs are available and completed daily. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. All staff has been in-serviced regarding storage of medications and refrigerator temperature logs by the SDC on 8/2, 8/5, and 8/6/2013. All refrigerators which store medications will be monitored daily by the unit managers (see Attachment K included with 2567 front page fax). 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of the audits will be forwarded to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue daily for 30 days then weekly for 30 days and then</p>		

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	<p>"...Keep medications requiring "refrigeration" or "temperatures between 2 degrees Celsius (36 degrees Fahrenheit) and 8 degrees Celsius (46 degrees Fahrenheit)" in a refrigerator with a thermometer to allow temperature monitoring...."</p> <p>During an interview on 7/18/13 at 8:52 A.M., the Administrator indicated, the Maplewood unit medication refrigerator did not have temperature logs which indicated the temperature had not been monitored from July 1, 2013 through July 17, 2013.</p> <p>3.1-25(m)</p>				monthly for 6 months to ensure continued compliance.		

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview, and record review, the facility failed to promptly develop an appropriate plan to correct identified dietary issues related to cold food and extensive wait times for meals to be served. This deficient practice had the potential to affect 103 of 103 residents who resided in the facility.</p> <p>Findings include:</p>	F000520	<p>F520-Committee-Members/Meet Quarterly/Plans: 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Effective 7/15/13, facility revised serving times and staff allocation to ensure 2 staff members are available in the main dining room 15 minutes prior to serving time to pass all drinks and serve trays timely. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and</p>		08/17/2013		

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	<p>On 7/9/2013 at 11:30 A.M., an observation of a sign posted by the Rosewood Cafe dining area was made. The sign indicated, breakfast was served at 8:15 A.M., lunch was served at 12:15 P.M., and dinner was served at 6:15 P.M.</p> <p>Constant observations were made of the Rosewood Cafe dining room on 7/9/2013, beginning at 12:24 P.M. and ending at 1:25 P.M. The following observations were made:</p> <p>12:24 P.M.- 16 residents seated in the dining room waiting to be served. No food being served.</p> <p>12:31 P.M.- one staff offering only cold drinks at this time. She indicated she would come back and provide the hot drinks when she was done. Carts being filled with trays of food to be taken to other areas in the facility.</p> <p>12:35 P.M.- last person in the room was offered a cold drink.</p> <p>12:39 P.M.- residents who wanted hot drinks were served hot drinks.</p> <p>12:50 P.M.- last resident who wanted a hot drink was served his drink.</p> <p>12:52 P.M.-first tray delivered to a resident. At this time, two staff observed serving trays.</p> <p>1254 P.M.- second tray served to a resident</p> <p>12:56 P.M.- Resident yelled out,</p>				<p>state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Effective 7/15/13, facility revised serving times for all dining areas and staff allocation to ensure enough staff in each serving area to provide food timely. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Facility in-serviced nursing and dietary staff on 7/12/13, to educate staff on new dining plan. Serving times were revised for accuracy and staff were re-assigned to different areas to ensure enough staff in each location to provide residents timely meal service. Administrator and Director of Nursing in-serviced by regional Director of Operations on Quality Assurance process and effective process improvement. The Dietician or designee will complete an audit of the meal service 3x daily for first 2 weeks, 1x daily for next 2 weeks, then 3x weekly for 30 days, then 1x weekly for 30 days. This will include timeliness of meals being served, food temps and interview of 3 residents each day alternating the resident who eat in the dining room and the resident who eat in their room (see Attachment I included with 2567</p>		

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	<p>"Where is the food." Staff responded, "Its coming, we are running behind." 1:05 P.M.-12 of [now] 20 residents sitting in the dining room had not been served lunch. 1:10 P.M.- 10 residents not served lunch 1:16 P.M.- 5 residents still not served lunch. 1:17 P.M.- Resident A was served ice cream. Staff removed the lid when they brought. The ice cream was melted almost to liquid. 1:18 P.M.- Resident A was asked if he liked his ice cream melted. He replied,"No, but it's that way by the time it gets here." 1:20 P.M.- the last resident in the room was served lunch</p> <p>During observations on 7/10/2013 at 12:42 P.M., staff served Resident A ice cream that was near liquid consistency. Resident A stated, "Yes, it is liquid again today."</p> <p>Interviews with residents and family:</p> <p>7/9/2013 at 11:50 A.M., Resident P indicated, at times her food is cold. Her toast was usually burned and she ate a lot of peanut butter and jelly sandwiches because the food was not so good.</p>		front page fax). The resident council minutes will be reviewed by the Administrator and Dietician following the meeting to ensure timely follow up of dietary concerns. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Facility will include meal timeliness monitoring in our monthly quality assurance review for next 6 months to ensure deficient practice does not recur. Regional Director of Operations will review all Quality Assurance minutes to ensure that identified concerns are appropriately worked through the quality assurance process for the next 6 months to ensure the deficient practice does not recur.				

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	<p>7/9/2013 at 12:05 P.M., Resident N indicated, her food was cold more than it was not.</p> <p>7/9/2013 at 12:15 P.M., Resident L stated, "cold is warm and hot is warm by the time they get it too you.... You drink the ice cream. It was that way today. Pretend it is a shake and go on if you like warm ice cream.... Yes, I have not eaten because it was too cold or too hot when it should have been cold."</p> <p>7/9/2013-12:30 P.M.-Resident C stated, "There is usually only one or two staff in here serving, cutting, and setting up trays. They need something. I swear.... We are supposed to be served at 12:15. I come down here at 12:00 ."</p> <p>7/9/2013-1:22 P.M.- Resident B's family member stated, "He has been here since 11:30 A.M.,.... He didn't get his food until after 1:00 today. That is too long... Sometimes he gets so disgusted he will wheel himself back to his room without eating. He has done that several times...."</p> <p>7/9/2013 at 1:28 P.M., Resident E indicated, meals were served late and ninety percent of the time she didn't get what she ordered.</p>						

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	<p>7/10/2013-9:55 A.M., Resident F indicated, most of the time the food was not appetizing. It was continually cold and usually late because there was not enough staff.</p> <p>7/10/2013 -10:28 A.M.- Resident D stated, "I eat in my room. Sometimes it is cold. No certain meal. It depends on how long it takes to get here and how warm it is when it leaves the kitchen.... The ice cream is usually pretty soft when I get it...."</p> <p>7/10/13 at 10:44 A.M., When asked if the food taste good and looked appetizing Resident G replied, "It sucks. The ice cream is like a milkshake. It is drinkable.... I am so displeased with the food, I don't eat it...I have told every body." He further indicated the food was not served at proper temperatures and his family had to bring him food from the outside.</p> <p>7/10/2013 at 11:21 A.M., Resident I indicated once and a while there was not enough staff to serve trays and it happened again last night.</p> <p>7/11/2013 at 9:49 A.M., When asked if the food was served at the proper temperature, Resident H responded, "some of it is cold...everyday its cold."</p>						

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	<p>7/10/2013 at 10:05 A.M., Resident K indicated she ate in the dining room. Her eggs were sometimes cold. She had to wait a long time to be served at all meals. She further indicated she felt it was sometimes due to staff "not taking their job seriously" and "sometimes their was just not enough staff down there."</p> <p>7/10/2013 at 11:38 A.M., Resident O indicated she had to wait up to an hour to be served at times in the dining room.</p> <p>7/10/2013 at 1:57 P.M., Resident M indicated, he ate in his room and sometimes his food was cold.</p> <p>7/11/2013 at 1:14 PM, Resident F stated, "The food is awful. I spoke to the chef. It is cold...and no variety."</p> <p>7/15/2013 at 8:41 A.M., Resident F was observed eating breakfast. At this time she indicated, her food wasn't any better today because her eggs were cold again.</p> <p>Interview with facility staff:</p> <p>7/9/2013 at 1:32 P.M., Licensed staff #14 stated, "It happens frequently. The start times are late. There isn't</p>						

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	<p>enough help in here to serve. The office is supposed to help but they don't.... Staff will come to the window to pick up there own lunch while residents are sitting and waiting to eat.... Something needs to be done."</p> <p>7/15/2013 at 9:53 A.M., Dietary Staff #13 indicated, she felt the problem with the food being cold and long wait times had to do with not enough servers and getting late starts in the kitchen.</p> <p>7/15/2013 at 9:56 A.M., the Dietary Manager stated, "We are constantly having to page to get people down here to help pass trays. We are short staffed in the kitchen Four people now. Two quit last week. We were already short so we run behind a little but we usually catch up and then we have to wait and wait for staff to pass trays. The food is hot when it goes out because we take temps [temperatures] but by the time it goes to the floor, it probably is cold, and that's the reason residents are complaining."</p> <p>Resident Council Minutes were reviewed for the months of January 2013 through June 2013. The minutes for February 2013, indicated, Resident felt there "was not enough</p>						

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	<p>staff at times." The minutes for March 2013 indicated, Residents felt there needed to be more staff. The minutes for April 2013, indicated, Residents had complaints of "food not being warm enough" and "wait times for meals." The minutes for May 2013, indicated, Residents had complaints of the "food not always being hot enough", the "ice cream is melted at times", and "meals are late at times."</p> <p>During an interview on 7/16/2013 at 9:24 A.M., the Administrator indicated the facilities Quality Assessment Committee had identified concerns with cold food and residents having to wait long periods of time to be served meals through observations and the Resident Council Minutes. She indicated the Resident Council Minutes in March alluded to problems with cold food and wait times, however, audits had not been started until July 1, 2013, to address the concerns.</p> <p>This Federal tag relates to Complaint IN00131013.</p> <p>3.1-52(b)(2)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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